General Assembly **Substitute Bill No. 372**

February Session, 2016 *____SB00372INS__031716___*

AN ACT CONCERNING CLINICAL REVIEW CRITERIA FOR UTILIZATION REVIEW AND ADVERSE DETERMINATION NOTICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 38a-591c of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(a) (1) Each health carrier shall contract with (A) health care professionals to administer such health carrier's utilization review program, and (B) clinical peers to evaluate the clinical appropriateness of an adverse determination.

(2) (A) Each utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically by the health carrier's organizational mechanism specified in subparagraph (F) of subdivision (2) of subsection (c) of section 38a-591b to assure such program's ongoing effectiveness. **[**A**]**

(B) Except as provided in subdivisions (3), (4) and (5) of this subsection, a health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner, provided such clinical review criteria conform to the requirements of subparagraph (A) of this subdivision.

(C) Each health carrier shall (i) post on its Internet web site (I) any clinical review criteria it uses, and (II) links to any rule, guideline, protocol or other similar criterion a health carrier may rely upon to make an adverse determination as described in subparagraph (F) of subdivision (1) of subsection (e) of section 38a-591d, as amended by this act, and (ii) make its clinical review criteria available upon request to authorized government agencies.

(3) **[**(A) Notwithstanding subdivision (2) of this subsection, for**]** For any utilization review for the treatment of a substance use disorder, as described in section 17a-458, the clinical review criteria used shall be: **[**(i)**]** (A) The most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions; or **[**(ii)**]** (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, **[**in accordance with subparagraph (B) of this subdivision**]** except that nothing in this subdivision shall prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional clinical review criteria from qualified vendors approved by the commissioner, to address advancements in technology or types of care for the treatment of a substance use disorder, that are not covered in the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Any such clinical review criteria developed by a health carrier or purchased or licensed from a qualified vendor shall conform to the requirements of subparagraph (A) of subdivision (2) of this subsection.

[(B) A health carrier that uses clinical review criteria as set forth in subparagraph (A)(ii) of this subdivision shall create and maintain a document in an easily accessible location on such health carrier's Internet web site that (i) compares each aspect of such clinical review criteria with the American Society of Addiction Medicine Treatment

Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.**]**

(4) **[**(A) Notwithstanding subdivision (2) of this subsection, for**]** For any utilization review for the treatment of a child or adolescent mental disorder, the clinical review criteria used shall be: **[**(i)**]** (A) The most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument; or **[**(ii)**]** (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument, **[**in accordance with subparagraph (B) of this subdivision**]** except that nothing in this subdivision shall prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional clinical review criteria from qualified vendors approved by the commissioner, to address advancements in technology or types of care for the treatment of a child or adolescent mental disorder, that are not covered in the most recent guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument. Any such clinical review criteria developed by a health carrier or purchased or licensed from a qualified vendor shall conform to the requirements of subparagraph (A) of subdivision (2) of this subsection.

[(B) A health carrier that uses clinical review criteria as set forth in subparagraph (A)(ii) of this subdivision for children and adolescents shall create and maintain a document in an easily accessible location on such health carrier's Internet web site that (i) compares each aspect of such clinical review criteria with the guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent

Service Intensity Instrument, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the guidelines of the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument.**]**

(5) **[**(A) Notwithstanding subdivision (2) of this subsection, for**]** For any utilization review for the treatment of an adult mental disorder, the clinical review criteria used shall be: **[**(i)**]** (A) The most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare; or **[**(ii)**]** (B) clinical review criteria that the health carrier demonstrates to the Insurance Department is consistent with the most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare, **[**in accordance with subparagraph (B) of this subdivision**]** except that nothing in this subdivision shall prohibit a health carrier from developing its own clinical review criteria or purchasing or licensing additional clinical review criteria from qualified vendors approved by the commissioner, to address advancements in technology or types of care for the treatment of an adult mental disorder, that are not covered in the most recent guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare. Any such clinical review criteria developed by a health carrier or purchased or licensed from a qualified vendor shall conform to the requirements of subparagraph (A) of subdivision (2) of this subsection.

[(B) A health carrier that uses clinical review criteria as set forth in subparagraph (A)(ii) of this subdivision for adults shall create and maintain a document in an easily accessible location on such health carrier's Internet web site that (i) compares each aspect of such clinical review criteria with the guidelines of the American Psychiatric

Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare, and (ii) provides citations to peer-reviewed medical literature generally recognized by the relevant medical community or to professional society guidelines that justify each deviation from the guidelines of the American Psychiatric Association or the most recent Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare.**]**

Sec. 2. Subsection (e) of section 38a-591d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2017*):

(e) Each health carrier shall provide promptly to a covered person and, if applicable, the covered person's authorized representative a notice of an adverse determination.

(1) Such notice may be provided in writing or by electronic means and shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(A) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount;

(B) The specific reason or reasons for the adverse determination, including, upon request, a listing of the relevant clinical review criteria, including professional criteria and medical or scientific evidence and a description of the health carrier's standard, if any, that were used in reaching the denial;

(C) Reference to the specific health benefit plan provisions on which the determination is based;

(D) A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

(E) A description of the health carrier's internal grievance process that includes (i) the health carrier's expedited review procedures, (ii) any time limits applicable to such process or procedures, (iii) the contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and (iv) a statement that the covered person or, if applicable, the covered person's authorized representative is entitled, pursuant to the requirements of the health carrier's internal grievance process, to receive from the health carrier, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the covered person's benefit request;

(F) (i) (I) **[**If the adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (i) the specific rule, guideline, protocol or other similar criterion, or (ii) (I)**]** A copy of the specific rule, guideline, protocol or other similar criterion the health carrier relied upon to make the adverse determination, or (II) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request, **[**(II)**]** with instructions for requesting such copy, and **[**(III)**]** (ii) the links to such rule, guideline, protocol or other similar criterion on such health carrier's Internet web site; **[**. If the adverse determination involves the treatment of a substance use disorder, as described in section 17a-458, or a mental disorder, the notice of adverse determination shall also include, if applicable, a link to the document created and maintained by such health carrier pursuant to subdivision (3), (4) or (5) of subsection (a) of section 38a-591c, as applicable, on such health carrier's Internet web site;**]**

(G) If the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the

adverse determination and (i) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances or (ii) a statement that an explanation will be provided to the covered person free of charge upon request, and instructions for requesting a copy of such explanation;

(H) A statement explaining the right of the covered person to contact the commissioner's office or the Office of the Healthcare Advocate at any time for assistance or, upon completion of the health carrier's internal grievance process, to file a civil action in a court of competent jurisdiction. Such statement shall include the contact information for said offices; and

(I) A statement that if the covered person or the covered person's authorized representative chooses to file a grievance of an adverse determination, (i) such appeals are sometimes successful, (ii) such covered person or covered person's authorized representative may benefit from free assistance from the Office of the Healthcare Advocate, which can assist such covered person or covered person's authorized representative with the filing of a grievance pursuant to 42 USC 300gg-93, as amended from time to time, (iii) such covered person or covered person's authorized representative is entitled and encouraged to submit supporting documentation for the health carrier's consideration during the review of an adverse determination, including narratives from such covered person or covered person's authorized representative and letters and treatment notes from such covered person's health care professional, and (iv) such covered person or covered person's authorized representative has the right to ask such covered person's health care professional for such letters or treatment notes.

(2) Upon request pursuant to subparagraph (E) of subdivision (1) of this subsection, the health carrier shall provide such copies in accordance with subsection (a) of section 38a-591n.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2017*	38a-591c(a)
Sec. 2	*January 1, 2017*	38a-591d(e)

Statement of Legislative Commissioners:
In Section 1(a)(3), (4) and (5), "(i)" and "(ii)" were changed to "**[**(i)**]** (A)" and "**[**(ii)**]** (B)", respectively, for consistency with standard drafting conventions, and in Section 1(a)(4), "an" before references to adolescent were deleted for clarity.

INS *Joint Favorable Subst. -LCO*